

**George W. Stevens**

**Dept. Veterans'  
Affairs**

**NKM07257**

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**George Stevens, NKM07257 VRB Page Summary**

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74 to 75.	6/10/2008	My Request for Review of Decision
	76	28/10/2008 Last Page of Sylvestre Report
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**DEPARTMENTAL SECTION 137 REPORT FOR REFERRAL  
TO VETERANS' REVIEW BOARD UNDER VETERANS'  
ENTITLEMENT ACT 1986**

***Veteran's Details***

Name: **George Stevens**  
Address: Po Box 18  
Berowra Heights 2082  
Telephone: 02/94564007  
Date of Birth: 10 February 1929

D.V.A File no. : **KM07257**  
V.R.B No: **N08/1126**  
Type: ASS  
Service No: 32734  
Arm of Service: NAVY  
D.P. rate 90%  
effective from 23/11/2007

- **DECISION UNDER REVIEW:** Repatriation Commission Decision dated 23 July 2008, that bilateral angle closure glaucoma, GORD, chronic gastritis, diverticular disease, IHD with congestive cardiac failure, colorectal adenoma with iron deficiency anaemia and conductive hearing loss are not related to service. DP is increased to 90%.

HISTORY OF APPLICATION	
Date of lodgement of informal claim/application	
Date of lodgement of formal claim/application	23/11/2007
Date of primary decision	23/07/2008
Date of notification of primary decision	23/07/2008
Date of lodgement of application to Veterans' Review Board	08/10/2008

Attached are tables of the following

1. Veteran Community Details Report
2. Section 137 Index to Documents
3. Cover prepared by Sue Wardropper

# Vet an Community Details Report



Australian Government

Department of Veterans' Affairs

**NKM07257 , GEORGE W STEVENS , Veteran, ACTIVE FILENO**

## **Contact Details**

Postal Address ..... Po Box 18

Berowra Heights Nsw 2082

Residential Address ..... 16 Wymah Cres

Berowra Heights Nsw 2082

Residential (Internet) ..... (02) 9456 4007

Telephone Allowance ..... Yes

## **Service Details**

24/09/1946, 02/01/1949, Navy, R32734

27/10/1953, 02/06/1954, Navy, R32734

22/03/1945, 31/05/1945, Australian Mariner

Qualifying Service Details

Australian - World War 2, Approved, 15/06/2002



**Australian Government**  
**Department of Veterans' Affairs**

**S.137 REPORT TO THE VETERANS' REVIEW BOARD  
INDEX SHEET**

Name: <b>George STEVENS</b>			DVA File No: <b>KM07257</b>	
Date Received	Description of Document	DVA M File Folio	Report Folio	T Doc. No.
23/11/07	Lifestyle questionnaire dd 18/11/07	133-136	3-9	T3
23/11/07	Claim	137-144	10-26	T4
2/1/08	Audio dd 20/12/07	163-164	27-28	T5
9/7/08	Dr Antoon's reports/medical impairment assessment forms dd 18/6/08	180-203	29-52	T6
23/11/07	Combined impairment assessment	223-228	53-58	T7
23/7/08	R C Decision	231-245	59-73	T8
8/10/08	Application for VRB review	247-248	74-75	T9
28/10/08	Section 31 non-intervention file minute	249	76	T10

Report compiled by Lee Domecillo on 21/11/08  
Photocopied by Vasantha



Australian Government  
Department of Veterans' Affairs

# Lifestyle Questionnaire

(Revised in consultation with ex-service organisations)

You should only complete this form if you want the Department of Veterans' Affairs to assess a lifestyle rating for you based on the information you provide.

It is **important** to remember that, when assessing your lifestyle, you should only claim for effects of disabilities that:

- are war and/or defence caused; and
- have been accepted by the Department; or
- you are claiming for in this disability claim.

Any disabilities that are **not** war and/or defence caused will **not** be considered when assessing your lifestyle rating.

The form has four parts of equal importance:

- **personal relationships;**
- **mobility;**
- **recreational and community activities; and**
- **domestic and employment activities.**

The information you provide on this form will assist in determining your rate of pension. The information will be treated in a confidential manner. In certain circumstances, however, it may be disclosed to:

- your Local Medical Officer to provide assistance to you; or
- the Veterans' Review Board, the Administrative Appeals Tribunal, or the Federal Court in the event of an appeal against a decision.

**Only answer the questions that you consider apply to your accepted or newly claimed disabilities.** You are not obliged to answer questions you do not want to, or questions that are not relevant to you.

## If you need help

You may wish to discuss your lifestyle with your spouse, other family members or a friend. It may be in your interest to talk to an ex-service organisation welfare officer or other qualified person. If you need more information or have difficulty filling out the appropriate form, please contact the Department of Veterans' Affairs in your State on the numbers on the following page.

When completed please return this form to the Department of Veterans' Affairs in your State.

## Personal Details

Your surname

STEVENS

Given names

GEORGE WOODFALL

Date of birth

10/2/1929

Veterans' Affairs file no. or your service no.

NKH 07257

Your signature

George Stevens 18/11/07

## Personal Relationships

This concerns how well you get on with other people.

1. Which of the following statements apply to you?  
(You may tick more than one box).

- ☐ Your personal relationships are unaffected by your disabilities.
- ☒ You are sometimes tense and a little anxious but still get on well with most people most of the time.
- ☐ You are often tense and irritable but still get on with some people fairly well.
- ☒ You don't sleep well.
- ☒ You often get cranky from pain.
- ☐ You find it difficult to discuss your problems.
- ☐ You are moody and irritable most of the time and usually find it difficult to get on with people.
- ☐ You are withdrawn and find it difficult to get on with other people.
- ☐ You have to depend on other people a lot.
- ☐ Your life is completely ruined.

2. How do you believe that your disabilities cause the above problems?

THE BACK PAIN CAUSES ALL  
THESE PROBLEMS. IT IS PRESENT  
ALL THE TIME

3. Do your disabilities affect your life with your family?

No ☐

Yes ☒ - please describe in what way

178  
They worry about me

4. Do your disabilities affect your social life?

No ☐

Yes ☒ - please describe in what way

Quite limited occasions when I  
am able to participate in any  
social event

5. Has there been a change in the way you get on with other people since the disabilities occurred (or got worse)?

No ☒

Yes ☐ - please describe in what way

6. This question is optional.

Do your disabilities affect your sexual feelings or abilities?

No ☐

Sometimes ☐

Yes ☒

Affected by medication  
and/or treatment ☐

You may describe if you wish

I HAVE NO INTEREST IN SEX

7. Does your medication affect your family or social life?

No ☐

Yes ☒ - please describe in what way

THE LASTX DRUG RESIDES ME  
TO MAINTAIN QUICK ACCESS TO  
TOILET FACILITIES. THE PAINKILLER  
PAIN KILLS SOMETIMES DON'T WORK  
& I GET CRANKY 4

# Mobility

This means your ability to move around in your usual surroundings. Your usual surroundings include your home that you usually visit. For example, church, shops, friends' houses.

It also includes your ability to use public transport or private cars to reach these locations and places.

## 8. Do you have any problems walking?

(Types of problems you may have affecting your mobility could include shortness of breath, or pain etc.)

No ☐ Yes ☒ - please give details below

Type of problem How often it occurs (please tick)

1. <u>ENERGY LOSS</u> <u>BACK PAIN</u> <u>SHORT DISTANCES</u> <u>ONLY 10-20</u> <u>100 METERS</u>	All of the time <input checked="" type="checkbox"/> Some of the time <input type="checkbox"/>
	Most of the time <input type="checkbox"/> Hardly ever <input type="checkbox"/>
	Depends on what I do and how fast I do it <input type="checkbox"/>

2. <u>CLIMBING/</u> <u>DESCENDING</u> <u>STAIRS</u>	All of the time <input checked="" type="checkbox"/> Some of the time <input type="checkbox"/>
	Most of the time <input type="checkbox"/> Hardly ever <input type="checkbox"/>
	Depends on what I do and how fast I do it <input type="checkbox"/>

3. <u>LIMITED</u> <u>ABILITY TO</u> <u>CARRY WEIGHT</u>	All of the time <input checked="" type="checkbox"/> Some of the time <input type="checkbox"/>
	Most of the time <input type="checkbox"/> Hardly ever <input type="checkbox"/>
	Depends on what I do and how fast I do it <input type="checkbox"/>

4. <u>SLOW PACE</u> <u>ONLY</u>	All of the time <input checked="" type="checkbox"/> Some of the time <input type="checkbox"/>
	Most of the time <input type="checkbox"/> Hardly ever <input type="checkbox"/>
	Depends on what I do and how fast I do it <input type="checkbox"/>

5.	All of the time <input type="checkbox"/> Some of the time <input type="checkbox"/>
	Most of the time <input type="checkbox"/> Hardly ever <input type="checkbox"/>
	Depends on what I do and how fast I do it <input type="checkbox"/>

## 9. Do you need something to help you move around, (crutches, wheelchair etc.)?

No ☐ Yes ☒ - what do you use?

WALKING STICK, BRACE  
NEGOTIATING STAIRS

How often do you use the device?

All of the time ☒

Only sometimes ☐

## 10. Do you need fittings in your house to assist mobility?

No ☐ Yes ☒ - please describe in what way

NO STAIRS OR STAIRS - RAMP OR  
LEVEL ACCESS

## 11. Do you need someone to help you move around or to go with you?

No ☐ Yes ☒ - what type of help do you need?

GETTING IN AND OUT OF  
CARS

## 12. Are there restrictions on your ability to sit in, or drive a car?

No ☐ Yes ☒ - please describe the restrictions

AFTER 15 MINUTES OR SO I AM  
VERY STIFF IN THE BACK.  
A SERIOUS PROBLEM IS THAT MY  
GLAUCOMA RESULTS IN POOR NIGHT  
VISION - I AM APPREHENSIVE ABOUT  
NIGHT DRIVING

## 13. Are there any forms of transport which you normally use, but have difficulty using?

No ☐ Yes ☒ - what forms of transport?

MY CAR & MY TRANSPORT WITHIN  
I CAN'T GET A SEAT

What difficulties do you have using the transport?

WITHOUT SOMEONE, TRAVELLING IS  
PAINFUL (IN THE BACK)

How often do the difficulties occur?

All of the time ☒

Only sometimes ☐

BUT I LIMIT  
TRAVEL TO AN  
ABSOLUTE  
MINIMUM



## Recreation and Community Activities

This concerns your ability to take part in social activities.

### 14. How often do you do the following things?

	A lot every day	A little every day	2 or 3 times weekly	Monthly	Rarely or never	Weekly or fortnightly
Visit or have visitors (e.g. friends or relatives)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Go out (e.g. to church, to watch sport, for entertainment, for meals or walks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play a sport (e.g. golf, tennis, bowls, fishing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Do a hobby (e.g. craft, music, art, stamp collecting cards, woodwork)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relax (e.g. reading, watching TV, listening to music)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do voluntary work (e.g. meals on wheels, welfare officer at RSL, Legacy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

### 15. Do you have difficulty doing any other activities because of your disabilities?

No ☒ Yes ☐ - please describe the difficulties


### 16. Are there any activities you have given up because of your disabilities?

No ☐ Yes ☒ - what are the activities?

Minor home modifications eg build shelves, paint rooms, change light fittings, change tap washers
---

## Domestic and Employment Activities

This concerns your ability to carry out common household tasks and your ability to work.

### Domestic Activities

### 17. How well can you do the following things?

	Easily	With difficulty	With help	If I take my time	I can't do it	I don't need to	Not Applicable
Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House cleaning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing up	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor house repairs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light gardening such as weeding and watering	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy gardening such as digging and pruning trees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lawn mowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing the car	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Knitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

18. Are there any domestic activities you have stopped doing because of your disabilities?

No ☐ Yes ☒ - what are the activities?

HOME IMPROVEMENTS  
MINOR REPAIRS  
WINDOW CLEANING

19. Are there any domestic activities which you have difficulty doing or take you longer than they used to?

No ☐ Yes ☒ - describe the difficulties

GENERAL TIDYING UP IN THE  
YARD, PUTTING OUT THE RUBBISH  
BINS, CHANGING BLOWN LIGHT GLASS

20. Does someone do things for you that you used to do?

No ☐ Yes ☒ - please describe these things

LAWN MOWING  
HEAVY GARDENING

## Employment Activities

21. Are you employed?

No ☒ - go to Question 31

Yes ☐ - go to Question 22

22. What is your occupation?

/

23. Is your employment full-time, part-time or casual?

/

24. How many hours per week do you normally work?

/

25. Have you changed jobs in the last 5 years?

No ☐ Yes ☒ - why did you change jobs?

/

26. Are there things you can't do at work that you used to do?

No ☐ Yes ☐ - what things can't you do?

/

Why are unable to do them?

/

27. Have you changed your workplace or the way you work to make it easier?

No ☐ Yes ☐ - what changes have you made?

/

Why did you make these changes?

/

28. Have you changed the hours you normally work?  
No ☐ Yes ☐ - why did you change the hours?

*/*

29. Have you lost any time from work during the past 12 months because of your disabilities?  
No ☐ Yes ☐ - how much time have you lost?

*/*

30. In your opinion, have your disabilities affected your future or career?  
No ☐ - go to Summary  
Yes ☐ - please describe in what way

*/*

Now go to Summary

*For those who have stopped working*

31. What year did you stop working?

1986

32. Why did you stop working?

Age ☐  
Ill-health ☐  
Other ☒ - please give reasons

WANTED TO WORK WITHOUT SUPERVISION & TO ACHIEVE MY OWN OBJECTIVES IN DOING COMMUNITY WORK (VOLUNTARY)

33. Did your disabilities stop you working in any way?  
No ☐ Yes ☒ - please describe in what way

NOT INDICATING, BUT DID SO AFTER A FEW YEARS

34. Have you sought or do you intend to seek employment?

No ☒ - go to Summary  
Yes ☐ - will your disabilities have any effect on your chance of employment?  
No ☐  
Yes ☐ - please describe in what way

### Summary

In this section you can put in your own words the effect your disabilities have on your lifestyle.

35. List the main ways your disabilities affect the way you live now.

I HAVE QUITE LIMITED PHYSICAL MOBILITY & I HAVE CONSTANT BACK PAIN - SOMETIMES HURT, SOMETIMES PROLONGED THIS HINDERS/EUMINATES MY OPPORTUNITIES TO PARTICIPATE IN GROUP/SOCIAL EVENTS.

Use this space if you would like to tell us further details about the effect your disabilities have on your life.

THE LEVEL OF FRUSTRATION IS HIGH. FOR MANY YEARS I HAVE HAD BOTH THE ABILITY AND MOTIVATION TO PERFORM IN PROJECTS. NOW THE MOTIVATION IS STILL THERE BUT THE ABILITY HAS GONE. MY 78 YEAR OLD BRAIN IS STILL VERY ACTIVE BUT THE 78 YEAR OLD BODY SIMPLY REFUSES TO OBEY THE LAWFUL CEREBRAL COMMANDS THAT I GIVE. THIS DESPITE THE BELIEF THAT I WILL SURVIVE FOR AT LEAST ANOTHER 10 TO 15 YEARS.

When you have completed this form please return it to the Department of Veterans' Affairs. The addresses are on page two of this form.

# PART A

## Representative's details

To be completed only if you wish to nominate a representative to act for you in matters relating to this application

- 1 Do you wish to nominate a representative or organisation to act for you in matters related to this claim?

No ☐ Go to Question 3

Yes ☒ Full name of nominated representative

MICHAEL SHAVE ACKNOWLEDGED

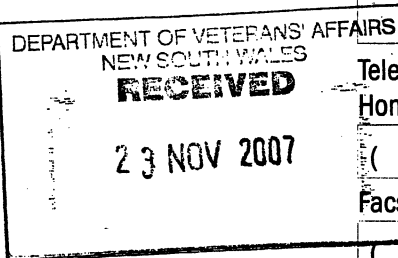
Organisation (if applicable)

VVFA

Address P.O. Box 170.

GRANVILLE

POSTCODE 2143.



Telephone

Home

( )

Facsimile

( )

Work

( ) 96821788

E-mail address

- 2 Is the representative trained under the Training and Information Program (TIP)?

No ☐

Yes ☐ To what level?

# PART B

## Veteran's details

- 3 DVA file number (if known)

NKM 07257

- 4 Title (Mr, Mrs, Dr etc.)

MR.

- 5 Surname

STEVENS

- 6 Given name(s)

GEORGE WOODFALL

- 7 Residential address

16 WYMAH CRESCENT

BEROWRA HEIGHTS

POSTCODE 2082

- 8 Postal address (if same as residential, write 'As Above')

PO Box 18

BEROWRA HEIGHTS

POSTCODE 2082

- 9 Telephone numbers

Home

(02) 9456 4007

Work

( )

- 10 Date of birth

10 / 2 / 1929

- 11 Marital status

Married ☒

Single ☐

Widowed ☐

Divorced ☐

De-facto ☐

12 Next-of-kin's name NANCY SHIRLEY STEVENS

13 Relationship to veteran WIFE

14 Next-of-kin's address 16 WYMAN CROSSING  
BEROWRA HEIGHTS POSTCODE 2082

15 Next-of-kin's telephone numbers Home (02) 9456 4007 Work ( ) /

## PART C

### What type of application are you making?

Tick the box or boxes that apply.

A. Claim for Disability Pension for disabilities that have not yet been accepted as service related ☒ Complete ALL questions (unless advised differently by question notes)

AND/OR

B. Application for Increase in Disability Pension for previously accepted disabilities (if your already accepted disabilities have worsened) ☒ Complete ALL questions from Question 25 onwards (unless advised differently by question notes)

16 Have you claimed a disability or service pension from this Department before? No ☐ Go to Question 18  
Yes ☒ In which State was the claim lodged? NSW Year lodged (if known) 1980

17 Have you had further service since your last claim? No ☒ Go to Question 20  
Yes ☐ Go to Question 18

## PART D

### Your service details

18 Please provide known details of your service in Australian forces and forces of other countries

If insufficient space, please attach a separate sheet giving the required details

NOTE: The Department of Veterans' Affairs will approach the Department of Defence for full details of your service. The information you provide will ensure the inquiries are directed to the appropriate area within Defence.

Service number	Unit or branch of service (include part-time reservist)	Enlistment and discharge dates (show actual dates, if known)	Nature of duties
	<u>SEE FILE</u>		
		/ / to / /	
		/ / to / /	
		/ / to / /	

**Merchant Mariners only**

Name of ship	Rank or grade	Name of owner or manager	Port of registration	Non-Australian ports visited	Voyage dates
					From / /
					To / /
					From / /
					To / /

If insufficient space, please attach a separate sheet

**19** Did you serve under any other name?

No ☐ Yes ☐ What was the name?

**PART E**

**Details of the NEW disabilities you are now claiming as war or defence caused**

If you are not claiming for acceptance of new disabilities go straight to **Question 25**.

**To be filled in by the VETERAN**

**20** List the disabilities you are now claiming and describe the signs and symptoms.

Please provide the diagnosis of the disability, if you know what it is. If you don't know what the diagnosis is, please describe as fully as you can the signs and symptoms that make you notice the disability (for example, pain in lower back, shortness of breath, loss of range of movement in arm).

**Do not include any injury or disease already accepted as war or defence caused.**

You are requested to ask your doctor to fill in the Medical Practitioner column next to this section before lodging your claim.

**To be filled in by a MEDICAL PRACTITIONER**

**For each disability the veteran is claiming, provide a diagnosis indicating whether the diagnosis is final or provisional.** A final diagnosis is preferred.

Please supply a brief summary of the basis for each diagnosis. Please attach any reports you have that confirms the diagnosis/es.

The Department will pay you for this service according to *The Schedule of Fees*.

**Note:** An account must be lodged before payment can be made.

Disability

**1**

**GLAUCOMA**

Signs and symptoms

REPORT OPHTHALMIC SURGEON R. D.  
SYMPTOMS REPORT DATED 7/5/2003  
COPY ATTACHED. PRESSURE CHECKED  
EVERY 3 MONTHS. MEDICATION NOW  
LUMIGAN  
ATTACHMENT # 1

**Medical diagnosis**

Diagnosis **GLAUCOMA**

Basis for diagnosis **eye specialist**

How do you believe your service caused, contributed to, or aggravated this disability?

THERE IS NO FAMILY HISTORY OF THIS. AS THE  
CONDITION WAS DIAGNOSED SOON AFTER 14 YEARS OF  
CONTINUOUS NAVAL SERVICE, IT COULD BE ASSUMED  
THAT THIS SERVICE SOMEHOW CONTRIBUTED TO THE  
ONSET OF THIS CONDITION. CAUSED BY CATARACTS.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

(ALREADY ACCEPTED)

When did the veteran first consult you for this condition?

NOV. 2004

Disability

2

ANAEMIA

Signs and symptoms

REFER ATTACHED BLOOD TEST RESULTS DATED 10/7/07, 28/9/07, 12/10/07, 31/10/07

ATTACHMENT # 2.

Medical diagnosis

Diagnosis ANAEMIA

Basis for diagnosis DR CHONG (Gastroenterologist)  
2<sup>nd</sup> to polyp (colonic)

How do you believe your service caused, contributed to, or aggravated this disability?

I AM UNABLE TO GIVE A DEFINITIVE RESPONSE TO THESE 2 QUESTIONS, OTHER THAN TO STATE THAT I FEEL THAT SOME OF THE MEDICATION PROVIDED TO EASE THE DISCOMFORT AND PAIN OF THE

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

When did the veteran first consult you for this condition?

JUNE 2010

Disability

3

REFLUX OESOPHAGITIS, GASTRITIS, DIVERTICULUM DISEASE, COLON POLYPS

Signs and symptoms

REFER ATTACHED REPORT DATED 31/8/07 FROM DR CHONG FOOD CHOICE

ATTACHMENT # 3

Medical diagnosis

Diagnosis REFLUX OESOPHAGITIS  
GASTRITIS  
DIVERTICULUM DISEASE

Basis for diagnosis DR CHONG

How do you believe your service caused, contributed to, or aggravated this disability?

SPONDYLOSIS CONDITION, SUCH AS THE NOW BANNED DRUG BUTOZOLATAN, HAS CUMULATIVELY HAD DELETERIOUS EFFECTS ON MY COLONIAL HEALTH OVER THE PAST 50 PLUS YEARS.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

When did the veteran first consult you for this condition?

JUNE 2010

**IMPORTANT** - So that your claim can be processed quickly:

- please have your doctor provide a diagnosis for each disability you are now claiming; and
- provide all relevant documents you may have relating to the disabilities.

**Doctor's stamp** (or address and telephone number)

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600  
( )

VRGP ☒

Non VRGP ☐

Doctor's signature

*[Signature]*

21/11/07

Please attach a separate sheet if you wish to claim for more than three (3) disabilities at this time.



NKM07257 – George W. Stevens

Part E

Disability 4.

Fluid around the heart and lungs

Refer attached Northside Medical  
Imaging – 53 report dated 5 November 2007.

Possible or contributory cause was working in  
stressful circumstances for a number of years  
in operational aircraft carriers, in particular  
during periods of military conflict, eg Korea, FESR.

8 C16H16N16 S16K16.  
ATTACHMENT # 4

Medical Diagnosis

Diagnosis CCF

Basis for diagnosis CT scan

under active

treatment

investigations

When did the veteran first consult you for this  
condition?

JAN 2007

**Part H – Details of Medical Treatment**  
**NKM07257 – George W Stevens**

Lumbar Spondylosis	A	1964 to 1971 1996.	Dr B Poynton Dr E Basset	GP GP
Solar Keratoses	A	2003	Dr B Killalea	GP
Tinnitus	A	2003	Dr B Kilalea	GP
Cataracts	A	2003 to 2004	Dr D Semmonds	Specialist
Glaucoma	NC	1982 to 2007	Dr D Rich Dr S Hollo Dr D Semmonds	Specialist Specialist Specialist
Reflux Oesophagitis	NC	2007	Dr J Antoon	GP
Gastritis	NC	2007	Dr M Bourke	Specialist
Diverticular disease	NC	2007	Dr C Choong	Specialist
Fluid around heart	NC	2007 2007 2007 2007	Dr J Antoon Dr A Aggarwala Dr G Goldin Dr R Brahmbhatt	GP Specialist Specialist Specialist
Anaemia	NC	2007	Dr J Antoon	GP

A = previously accepted as service related.  
NC = new claim



COMMONWEALTH DEPARTMENT OF  
VETERANS' AFFAIRS

## Additional Information Sheet

**NOTE:** This is not a claim form and must be used as an attachment to form D2582 'Claim for Disability Pension and/or Application for Increase in Disability Pension'

### Details of the NEW disabilities you are now claiming as war or defence caused

This column is to be filled in by the  
**Veteran**



List the disabilities you are now claiming and describe the signs and symptoms.

Please provide the diagnosis of the disability, if you know what it is. If you don't know what the diagnosis is, please describe as fully as you can the signs and symptoms that make you notice the disability (for example, pain in lower back, shortness of breath, loss of range of movement in arm).

**Do not include any injury or disease already accepted as war or defence caused.**

You are requested to ask your doctor to fill in the Medical Practitioner column next to this section before lodging your claim.

This column is to be filled in by a  
**Medical Practitioner**



For each disability that the veteran is claiming, provide a diagnosis indicating whether the diagnosis is final or provisional. A final diagnosis is preferred. **Please supply a brief summary of the basis for each diagnosis.** Please attach any reports you have that confirms the diagnosis/es.

The Department will pay you for this service according to *The Schedule of Fees*. Note: An account must be lodged before payment can be made.

Disability

5

HEARING LOSS.

Signs and  
symptoms

TROUBLE HEARING  
TV, RADIO, CONVERSATIONS.

Medical Diagnosis

Diagnosis

Basis for diagnosis

How do you believe your service caused, contributed to, or aggravated this disability?

IN THE NAVY I WAS EXPOSED  
TO VERY LOUD AIRCRAFT NOISE  
ON CARRIER FLIGHT DECKS, NO EAR  
PROTECTION WORN. ALSO EXPOSED  
TO LOUD BONFIRE.

When did you first become aware of the signs and symptoms of the disability, or aggravation of the disability? (approx. date if known)

When did the veteran first consult you for this condition?

Disability

5

Signs and symptoms

How do you believe your service caused, contributed to, or aggravated this disability?

When did you first become aware of the symptoms of the disability or aggravation of the disability? (approx. date if known)

Disability

6

Signs and symptoms

How do you believe your service caused, contributed to, or aggravated this disability?

When did you first become aware of the symptoms of the disability or aggravation of the disability? (approx. date if known)

## Medical Diagnosis

Diagnosis

Basis for diagnosis

## Medical Diagnosis

Diagnosis

Basis for diagnosis

When did the disability first become known to you?

Doctor's stamp (for dates and doctor's name)

REG ☐

Non-REG ☐

Doctor's signature

Payment of your account for this service can only be made after this form has been received.

So that your claim can be processed quickly:

- please have your doctor provide a diagnosis for each disability you are now claiming, and
- provide all relevant documents you may have relating to the disabilities.

( )

## Tobacco and Alcohol

**IMPORTANT** - Some conditions may be caused, contributed to, or aggravated by tobacco or alcohol consumption. If tobacco or alcohol consumption is relevant to any of the conditions you are now claiming, more information may be needed by the person handling your claim. Please tick the relevant boxes below so that the correct questionnaire can be sent to you or your representative. (4)

21 Have you ever smoked?

No ☐

Yes ☒

What type of tobacco product did the veteran use?

Cigarettes ☒

Pipe ☐

Cigars ☐

Tobacco ☐

22 Have you filled out a smoking questionnaire previously?

No ☐

Yes ☒

Can't remember ☐

23 Have you ever consumed alcohol?

No ☐

Yes ☒

24 Have you filled out an alcohol questionnaire previously?

No ☐

Yes ☒

Can't remember ☐

## PART G

## Reasons for this application for increase

To be completed only if previously accepted disabilities have become worse.

25 Which of your accepted disabilities have become worse since they were last assessed by the Department and in what way?

\* Lumbar Spondylosis  
 Stepping loss has increased  
 Solar keratosis  
 \* Cataract

For EXPLANATIONS OF HOW EACH OF THESE CONDITIONS HAS CHANGED SINCE THE LAST ASSESSMENT DURING MARCH 2003, PLEASE SEE ATTACHED STATEMENT "GEORGE W. STANIS DISABILITY PENSION REVIEW NOVEMBER 2007"

ATTACHMENT # 5

If insufficient space, please attach a separate sheet.

## Details of your medical treatment

- 26** Provide details of doctors and hospitals who have provided treatment or consultation for the disabilities which have been accepted as service related or those you are now claiming.

Disability treated	Date of treatment	Name of doctor/hospital etc.	Type of treatment or consultation provided (e.g. GP, specialist)
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		

If insufficient space, please attach a separate sheet.

- 27** Provide details of your local medical practitioner (not the specialist) who will provide ongoing treatment.

Local medical practitioner's name

Dr John Antoon

Address

Berown Family Medical Practice

Po Box 217 Berown Heights POSTCODE 2082

Telephone

(02) 9456 2600

## PART I

## Details of your employment history (other than your service)

Please complete this section even if you are retired.

- 28** Are you currently employed?

No ☒

Date ceased work

/ 1986

Reason for ceasing work (e.g. age, illness, redundancy)

Early Retirement

Yes ☐

Name of current employer

How many hours per week do you work?


140

None

**If insufficient space, please attach a separate sheet.**

**30 Have the disabilities you are now claiming affected your employment or your ability to seek employment at any time?**

No ☒

Yes ☐ 

**Please give details**

[illegible]

**If insufficient space, please attach a separate sheet.**

## Other payments

If you lodge a claim for any other pension, benefit or allowance while this claim is being processed, you **MUST** advise the Department of Veterans' Affairs.

- 31 Do you receive, or have you applied for, any payment (e.g. the age pension from Centrelink), other than superannuation?**

No ☐

Yes ☐ ► Give details below

(Family Allowances are not required but other Centrelink payments must be included).

Type of benefit or pension	Name and address of source	Date of claim	Reference No. (if known)
SERVICE PENSION	D.V.A.	26 9/07	N1KM 07257
		/ /	
		/ /	
		/ /	

If insufficient space, please attach a separate sheet.

## PART K

## Compensation

- 32 Have damages/compensation been claimed or received from any other source for any of the disabilities you are now claiming (e.g. Comcare, Department of Defence, third party accident insurance)?**

No ☒

Yes ☐ ► Give details below

Nature of injury or disease	Name and address of source	Date of claim	Reference No. (if known)
		/ /	
		/ /	
		/ /	

If insufficient space, please attach a separate sheet.



**33** Do you currently receive a pension from the Department of Veterans' Affairs?

No ☐ Go to **Question 34**  
Yes ☒ Go to **Question 35**

(39)

**IMPORTANT** - If a pension is granted, it will be paid fortnightly into an account at an Australian bank, credit union or building society.

**34** Provide details of the Australian account you want your pension to be paid into

Name of bank, credit union or building society

Branch

Address

POSTCODE

Account in the name of

Account number

BSB number

Account type (e.g. savings)

Please complete Part M and Part N over page.

## Declarations

**Complete (a) OR (b) - A representative is not required to sign this form** unless they are legally authorised to act for a claimant who is incapable of signing due to their physical or mental incapacity.

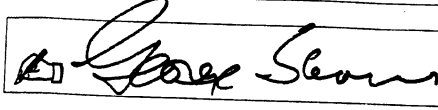
**35 (a) No representative appointed**

- I declare that the details I have given in this form are complete and correct.
- I am aware that there are penalties for making false statements.
- I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information needed to process, determine or review this claim.
- I consent to the release of medical, clinical or other information to the Department by any medical practitioner, hospital, clinic, insurance company, Centrelink, the Department of Defence or other organisation, in relation to this claim or its review.

\* Claimant's full name  
(please PRINT)

GEORGE HODGKIN STEVENS

\* Claimant's signature

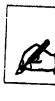
 18/11/07

**35 (b) Representative appointed**

- I declare that the details I have given in this form are complete and correct.
- I am aware that there are penalties for making false statements.
- I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information needed to process, determine or review this claim.
- I authorise the nominated representative or organisation to act for me in respect of this claim and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:
  - revoke this authorisation; or
  - nominate another representative or organisation to act for me.
- I consent to the release of medical, clinical or other information to the Department by any medical practitioner, hospital, clinic, insurance company, Centrelink, the Department of Defence or other organisation, in relation to this claim or its review.

\* Claimant's full name  
(please PRINT)

\* Claimant's signature

 / /

\* If the veteran is unable to sign, due to physical or mental incapacity, the Declaration must be signed by the person signing the Authority to act on behalf of the claimant at **Question 36** over the page.

## SMOKING QUESTIONNAIRE

138

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. The authority to obtain this information is also contained in this Act. We treat all personal information in strict confidence but, in the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

.....STEVENS.....GEORGE WOODFORD.....  
Surname First Names DVA File No.

(1) Have you ever smoked cigarettes/tobacco on a regular basis?

☐ NO Please sign the form and return it to the Department.

☒ YES Go to Question 2.

(2) In what year did you take up smoking? .....1946.....

(3) This was ☐ Before service

☒ During service

☐ After service

(4) Why did you take up smoking?

.....PEER PRESSURE.....  
.....  
.....

- (5) What quantities of cigarettes/tobacco did you smoke during the following periods? Describe any variations in the habit.

	Years (Dates if known)	Reason	Quantity
Before Service			
During Service	1946	PARK PRESSURE	10 CIGS A DAY.
After Service	1956	HABIT	10 CIGS A DAY.

- (6) Do you still smoke?



NO

When did you stop?

1956



YES

What is your average daily consumption now?

- (7) Are there any comments you wish to make in regard to your smoking habit?

No

SIGNED:

Gorge Stein

DATE: 11/11/57

**Authority to act on behalf of a claimant****36 Details of the person who is legally authorised to act on behalf of the claimant who is unable to sign this claim and/or application.**

**NOTE:** The person will usually be appointed by an enduring power of attorney to manage the affairs of the claimant or a family member or friend acting on their behalf, or will hold a medical certificate attesting to the incapacity.

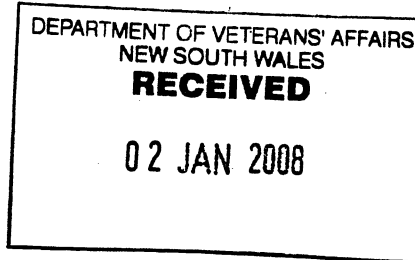
137

Full name	<input type="text"/>	
Address	<input type="text"/>	
	<input type="text"/>	
	POSTCODE	
Telephone	<input type="text"/>	<input type="text"/>
Home	( )	Work ( )

I declare that I am authorised to act on behalf of the claimant in matters relating to this claim and that the claimant is unable to sign due to physical or mental incapacity.

**IMPORTANT** - Please attach a copy of the instrument conferring this authority e.g. enduring power of attorney or a medical certificate attesting to the person's incapacity to sign. This information will be evaluated by the delegate for the purposes of approval.

Type of authority (e.g. power of attorney)	<input type="text"/>
Signature of authorised person (you must also sign the Declaration at Question 35)	<input type="text"/>



**Report For:** Mr George W Stevens  
**Address:** P.O. Box 18  
BEROWRA HEIGHTS 2082

**DOB:** 10/02/1929

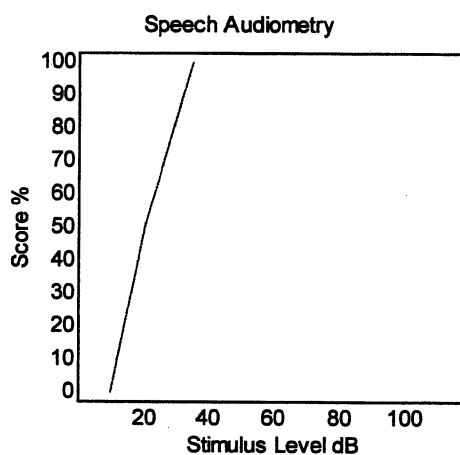
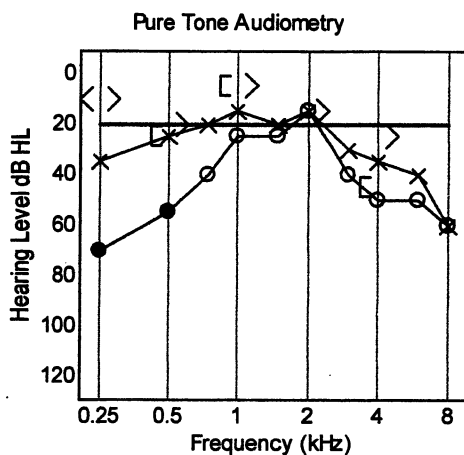
**Report Date:** 20/12/2007

**Test Date:** 20/12/2007

**Referred By:** Ms Elizabeth Pawlak

**Report To:** Ms Elizabeth Pawlak  
L16 Dept Veteran Affairs  
GPO Box 3994  
SYDNEY NSW 1141

Key to Symbols			
X, ■	Left Air, Masked	O, ●	Right Air, Masked
>, ]	Left Bone, Masked	<, [	Right Bone, Masked
□	Binaural	↓	No Response



Impedance Audiometry			
	Left	Right	
<i>Tympanogram Type</i>	A	A	
<i>MEP (daPa)</i>	12	36	
<i>Ear Canal Volume (ml)</i>	1.5	2.5	
<i>Peak Compliance (ml)</i>	0.5	0.9	
<i>Reflexes (dBHL)</i>	500 Hz	1 kHz	2 kHz
<i>Left Ipsi</i>	95	95	NR
<i>Left Contra</i>			
<i>Right Ipsi</i>	NR	NR	NR
<i>Right Contra</i>			
	Left	Right	
<i>Reflex Decay</i>			

## Report:

Pure Tone Audiometry indicated an asymmetrical MIXED hearing loss. The LEFT ear is mild in the lows, slight in the mids and moderate in the highs. The RIGHT ear is worse as it is moderate in the lows, mild in the mids and moderate in the highs with significant air-bone gaps recorded in the low to mid range, but not in the high range (Sensori-neural loss in the highs).

Speech tests at indicates good discrimination of A-B Word list material presented at appropriate levels.

Tympanometry indicated normal pressure - compliance variations in both ears (Type A Tympanograms).

Mr Stevens reports the perception of Tinnitus which he describes as "intermittent but annoying".

The results suggest that Mr Stevens should benefit from wearing hearing aids. He may also benefit from Assistive Devices such as Infra Red TV Listening Systems.

I will send a report to Mr Stevens GP Dr Antoon recommending ENT consult be considered because of the asymmetry.

Thank you for your referral. A copy of our Invoice is attached. Yours sincerely,

*Helen Williams* 20/12/07

Helen Williams, B.A. Dip Aud. MAudSA(c.c.p.)  
**Audiologist**

**Distribution:** Ms Elizabeth Pawlak, Dr JOHN ANTOON

**Name:** George W Stevens

Se: n Date: 20/12/2007

Client No: 0001402

Allen-Fisher Acoustics Ltd ABN 34063123580

43 Palmerston Rd, Hornsby 2077

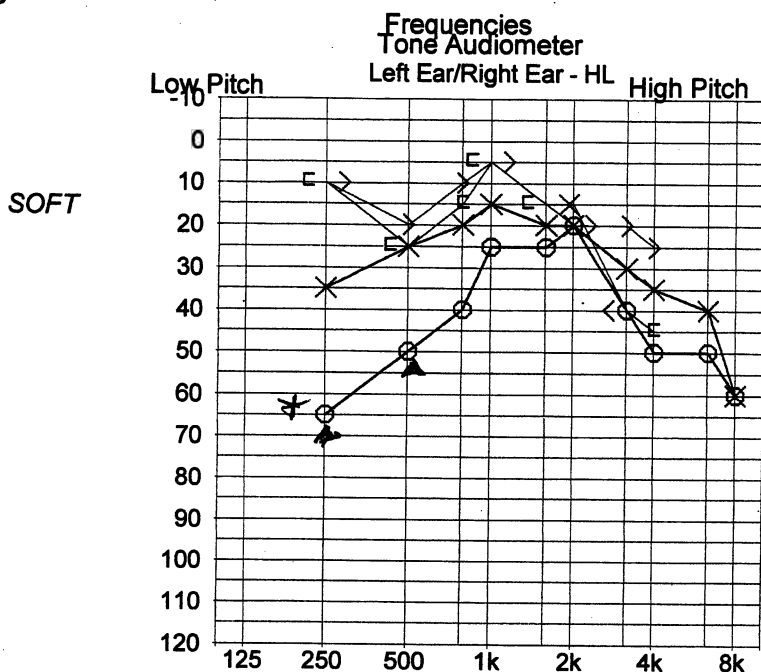
Ph 02 9476 0002, Fax 02 9476 5777

Client Na. George Stevens

Birth Date: 10/02/1929

User ID: ABC

### PURE TONE AUDIOGRAM



#### KEY:

O RIGHT

X LEFT

< B/C R

> B/C L

△ RIGHT MASKED A/C

#### OTOSCOPY

RIGHT: Canal } Clear.

LEFT: Canal } R/L.

Tested by Helen Williams

Audiologist

BA DipAud MAud SA c.c.p.

AC:			
BC:		40	40
SF:		40	30
SF A:		40	50
Masking Levels		* Possibility of Overmasking.	
Right	Masking	Left	Masking
SRT:		SRT:	
Right	Masking	Left	Masking
MCL:		Left	Masking
Right	Masking	Left	Masking
UCL:		Left	Masking
Right		Left	
PTA (A):		Left	

Unaided Discrimination:  
Right Level Masking Binaural Level Masking Left Level Masking

Aided Discrimination:  
Right Level Masking Binaural Level Masking Left Level Masking

Unaided Discrimination, noise:  
Right Level S/N Binaural Level S/N Left Level S/N

Aided Discrimination, noise:  
Right Level S/N Binaural Level S/N Left Level S/N

### TYMPANOMETRY

Notes

#### RIGHT

Type: A

MEP: 36 (mm H<sub>2</sub>O equ)

Comp: 0.86 (cc)

Vol: 2.8 (cc)

Ipsilateral Reflexes (Screening Levels at 95 dB SPL)

.5K

R NR

L 95

1K

NR

95

2K

NR

NR

#### LEFT

Type: A

MEP: 12 (mm H<sub>2</sub>O equ)

Comp: 0.52 (cc)

Vol: 1.50 (cc)

4K

NR

NR



Australian Government  
Department of Veterans' Affairs

V221  
Rec'd 9/7/08  
→ APQ 9/7/08  
\$459-80

Folio:.....203.....  
75

## Diagnostic Report - Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

Surname

Stevens

Given Names

George

DVA File Number

KM07257

### Report Detail

This veteran has lodged a disability claim for a condition provisionally diagnosed as glaucoma. The Department needs to establish the precise diagnosis in order to process the claim.

1. Please indicate the veteran's glaucoma status in each eye by ticking the appropriate boxes.

#### Right eye

No glaucoma

Primary open-angle glaucoma

Primary angle-closure glaucoma

↳ acute

↳ chronic

Secondary glaucoma

Other (please specify)

#### Left eye

No glaucoma

Primary open-angle glaucoma

Primary angle-closure glaucoma

↳ acute

↳ chronic

Secondary glaucoma

Other (please specify)

Rt eye still problem

2. If the veteran has secondary glaucoma please specify the form (e.g. ghost cell, neovascular, phacolytic, pigmentary) and whether the glaucoma is open-angle or angle-closure in type.

N/A.



3. Does the veteran suffer from any other disorders affecting vision?

- ☐ No  
☒ Yes - Please describe.

cataracts
removed + replaced

4. When was the clinical onset of the glaucoma (ie. the first symptoms or signs or other evidence)?

about 20 years / now

5. Would you like to make any other comments on the diagnosis of this condition?

no.


If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

**Details of Medical Practitioner providing advice:**

**Stamp**

DR JOHN ANTOON 1A TURNER ROAD BEROWRA HEIGHTS NSW 2082 Ph: 9456 2600
---

**Signature**

	12/6/02
---	---------



**Australian Government**  
**Department of Veterans' Affairs**

Folio:.....201.....

## Diagnostic Report - Anaemia, Unspecified

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### ***Veteran's Details***

**Surname**

**Stevens**

**Given Names**

**George**

**DVA File Number**

**KM07257**

### ***Report Detail***

This veteran has lodged a disability claim for anaemia, unspecified. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

ANAEMIA

? CHRONIC GASTRITIS / REFLUX

? SIGMOID TUBERCLE - VILLOUS ADENOMA.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☒ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. *(Please attach copies of relevant specialist reports or test results)*

see attached

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

1 year - Breastfeeding

6. What treatment has been given for this condition?

no reports of cholestasis

7. Are there any predisposing factors for the development of this condition?

no

8. Would you like to make any other comments on the diagnosis of this condition?

no

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

**Details of Medical Practitioner providing advice:**

Stamp

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Signature

*[Signature]*

18/10/00



## Medical Report - Open-Angle Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### *Veteran's Details*

Surname

Stevens

Given Names

George

DVA File Number

KM07257

### *Report Detail*

A claim for service related compensation in respect of disability or death of the above named requires the Department to consider whether any of the following could be factors in the development or worsening of open-angle glaucoma. Would you please answer the following questions:

### *Surgical procedures affecting specific parts of the body*

Please mark and provide details if any of the following surgical procedures or other treatments has ever been provided to the veteran. Identify the date of treatment, the condition treated and the site and/or side of the body affected by the procedure or treatment:

Surgical procedure	Date of treatment	Provided for	Site and/or side of body treated
<input type="checkbox"/> intraocular surgery or penetrating keratoplasty	/ /		

no.

### *Details of Medical Practitioner providing advice:*

Stamp

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Signature

18, 06, 02



Australian Government  
Department of Veterans' Affairs

Folio:...../..66.....

## Diagnostic Report - Chronic Gastritis

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

Surname

Stevens

Given Names

George

DVA File Number

KM07257

### Report Detail

This veteran has lodged a disability claim for chronic gastritis. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

CHRONIC GASTRITIS on endoscopy, new biopsy results.  
REFLUX OESOPHAGITIS.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;  
☐ Provisional / differential diagnosis: further investigation or referral required;  
☒ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. (Please attach copies of relevant specialist reports or test results)

new results.

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

- no significant stomach symptoms  
- condition diagnosed coincidentally whilst having investigation for anaemia.

6. What treatment has been given for this condition?

some fong Tbb

7. Are there any predisposing factors for the development of this condition?

stress / related to past service

8. Would you like to make any other comments on the diagnosis of this condition?

no.


If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

### Details of Medical Practitioner providing advice:

#### Stamp

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

#### Signature

 18/06/00



Australian Government

Department of Veterans' Affairs

Folio:.....146.....

## Diagnostic Report - Diverticular Disease Of The Colon

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

Surname

Stevens

Given Names

George

DVA File Number

KM07257

### Report Detail

This veteran has lodged a disability claim for diverticular disease of the colon. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

mild-moderate diverticular disease  
new report 31/Aug/07 D-choong.

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;  
☐ Provisional / differential diagnosis: further investigation or referral required;  
☒ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. (Please attach copies of relevant specialist reports or test results)

new attached report 31/Aug/07  
D-choong.

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

N/A.

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

diagnosed while being investigated for anaemia  
no current symptoms

6. What treatment has been given for this condition?

high fibre diet

7. Are there any predisposing factors for the development of this condition?

No.

8. Would you like to make any other comments on the diagnosis of this condition?

No.

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

**Details of Medical Practitioner providing advice:**

**Stamp**

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

**Signature**



18/6/00





**Australian Government**  
**Department of Veterans' Affairs**

Folio:.....199.....

## Diagnostic Report - Congestive Cardiac Failure

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

**Surname**

**Stevens**

**Given Names**

**George**

**DVA File Number**

**KM07257**

### Report Detail

This veteran has lodged a disability claim for congestive cardiac failure. The Department needs to establish the correct diagnosis in order to process this claim. Could you please indicate below:

- your diagnosis or differential diagnosis for the claimed condition;
- to what extent this diagnosis has been established; and
- what further steps, if any, are needed to confirm the diagnosis.

1. What is the diagnosis / differential diagnosis for the claimed condition (indicate unknown if no relevant evidence available)?

HEART FAILURE CONGESTIVE new report 8/12/07
2-1 H INO.
Dr RAJESH
BR 01/MB/MT

2. To what extent has this diagnosis been established?

- ☐ Insufficient evidence to make a diagnosis at this stage;
- ☐ Provisional / differential diagnosis: further investigation or referral required;
- ☒ Diagnosis confirmed on clinical grounds and/or by relevant investigation.

3. Please provide the results of any investigations which have been performed. (Please attach copies of relevant specialist reports or test results)

new report 8/12/07

4. What further steps are necessary, if any, to confirm the diagnosis (please indicate specific investigations or type/s of specialist referral required)?

mi

5. When was the clinical onset of this condition (ie: the first symptoms or signs or other evidence)?

1st 1/2 of 2007  
(breathless)

6. What treatment has been given for this condition?

no medication 1st / 1010x (divertic)

7. Are there any predisposing factors for the development of this condition?

ex smoke

8. Would you like to make any other comments on the diagnosis of this condition?

no

If you have any problems completing this form you can phone the Department and discuss the matter with one of our medical officers.

**Details of Medical Practitioner providing advice:**

Stamp

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Signature

*[Signature]* 18/11/07



Australian Government  
Department of Veterans' Affairs

Folio:.....19.....

## Medical Report - Corticosteroid Therapy Open Angle Glaucoma

The information you provide on this form will assist in deciding eligibility for benefits under the Veterans' Entitlements Act 1986. In the event of an appeal against a decision, this information may be provided to the Veterans' Review Board, Administrative Appeals Tribunal or Federal Court.

### Veteran's Details

Surname

Stevens

Given Names

George

DVA File Number

KM07257

### Report Detail

A claim for service related compensation in respect of the abovenamed leads the Department to consider whether undergoing corticosteroid therapy could be relevant to the development of open angle glaucoma in this case. Would you please answer the following questions:

1. When was the clinical onset of open angle glaucoma?

20-25 years

2. Has the glaucoma permanently worsened at any time?



No



Yes - Please indicate when this happened.

- present and lost 20-25 years

- condition stable with treatment

no cause known.

	<b>Treated</b>	<b>Right Eye</b>	<b>Commenced</b>		<b>application eg daily</b>
N/A					

#### Corticosteroid containing dermal preparations

<b>Medication Used</b>	<b>Condition Treated</b>	<b>Site of application</b>	<b>Date Commenced</b>	<b>Date Finished</b>	<b>Frequency of application eg daily</b>
N/A					

#### Oral corticosteroids

<b>Medication Used</b>	<b>Condition Treated</b>	<b>Date Commenced</b>	<b>Date Finished</b>	<b>Frequency of dose eg daily</b>
N/A				

**Corticosteroid injections**

Medication Used	Condition Treated	Date of Injection
N/A.		

**A subconjunctival repository steroid injection or an orbital/periocular corticosteroid injection**

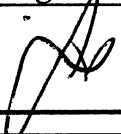
Medication Used	Condition Treated	Date of Injection	Left or Right Eye
N/A.			

**Details of Medical Practitioner providing advice:**

**Stamp**

DR JOHN ANTOON 1A TURNER ROAD BEROWRA HEIGHTS NSW 2082 Ph: 9456 2600
---

**Signature**

 18, 11, 02
---

Stevens

George

KM07257

### Report Detail

A claim for service related compensation in respect of the abovenamed leads the Department to consider whether helicobacter pylori infection could be a factor in the development of Chronic Gastritis. Would you please answer the following questions:

1. When was the clinical onset of Chronic Gastritis?..... *1 year diagnosed and started*
2. Has the veteran ever been tested for infection with Helicobacter pylori? *while investigating*
- ☐ No *order in*
- ☒ Yes - Please provide results (attach additional results if insufficient space):

Date of Test	<i>31 / 8 / 07</i>	Result:	<i>negative</i>
Date of Test	/ /	Result:	
Date of Test	/ /	Result:	
Date of Test	/ /	Result:	

3. Has the veteran ever received treatment for the eradication of Helicobacter pylori?

- ☒ No - Please sign the form and return it to the Department
- ☐ Yes - Please provide details:

Date of Treatment	/ /	Comment:	
Date of Treatment	/ /	Comment:	
Date of Treatment	/ /	Comment:	

Topical applications

3. Does the condition restrict use of either upper limb, walking, dressing, hygiene or feeding?  
☒ No ☐ Yes U (describe the nature of the limitation for each of these categories)

Upper limb(s)

Walking

Dressing

Hygiene

Feeding

4. Does Solar Keratoses cause embarrassment or inconvenience in unfamiliar social settings, domestic life or intimate situations or curtail his participation in sporting or recreational activities?  
☒ No ☐ Yes U (provide details of when this occurs and describe the extent of the embarrassment)

5. Is the structural integrity of the face altered because of Solar Keratoses?  
☒ No ☐ Yes U (describe the changes; eg. partial or total loss of pinna, skin graft, noticeable scarring)

6. Has there been any deep invasion or dissemination of Solar Keratoses?  
☒ No ☐ Yes U (provide details, including the depth of invasion in mm, extent of spread, prognosis and treatment)

7. Are the described symptoms due solely to Solar Keratoses?  
☒ Yes ☐ No U (please describe the proportion Solar Keratoses contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

8. If you answered NO to the preceeding question, please list all other conditions that contribute to the symptoms.

MA  
Doctor's signature

DR JOHN ANTOON

440 TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date  
16/8/10

4. Has upper GIT disorders caused a change in body weight since its onset?

☒ No

☐ Yes U

(record actual or estimated body weight before first onset and current weight)

Weight before onset \_\_\_\_\_ kilograms

Current body weight \_\_\_\_\_ kilograms

5. Does he use any treatment for the condition?

☐ No

☒ Yes U

(provide details of medication, including dosage and frequency of usage, and comment on to what extent the condition responds to medication. List any permanent side-effects)

SPMAC 40mg b.i.

6. Has a restricted or exclusion diet been prescribed for upper GIT disorders?

☐ No

☒ Yes U

(please provide details)

HEALTHY DIET / Minimal alcohol / avoid NSAIDs / avoid smoking

7. Have any procedures been undertaken or proposed?

☐ No

☒ Yes U

(list all procedures undertaken or proposed. For stomas, state if temporary or permanent)

new report P, cholangy 31/AUG/02

8. Are the described symptoms due solely to upper GIT disorders?

☒ Yes


☐ No U

(please describe the proportion upper GIT disorders contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

9. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

Doctor's Signature

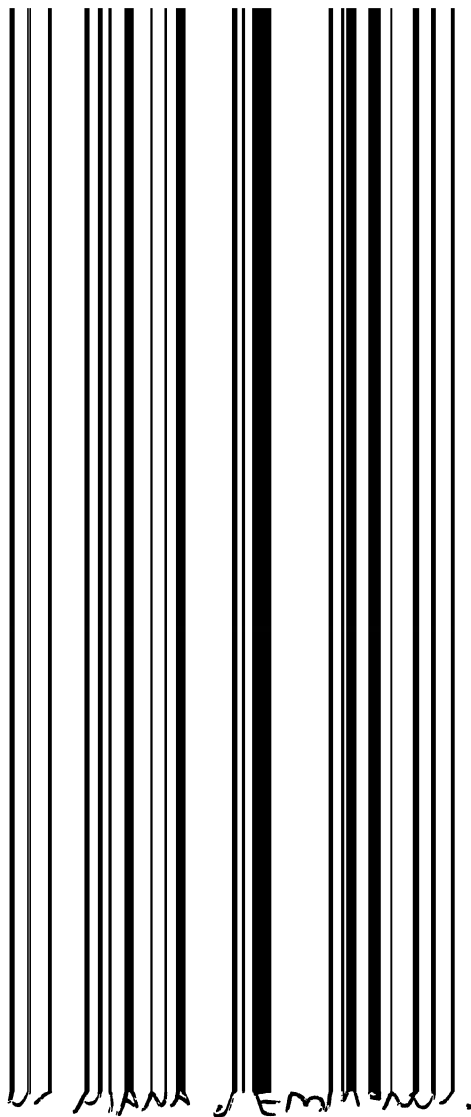


DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date

12/06/02





4. Are there any persistent side-effects of treatment?

☒ No

☐ Yes **U**

(describe the side-effects and state whether of a temporary or permanent nature)

5. Are the described symptoms due solely to eye conditions?

☒ Yes

☐ No **U**

(please describe the proportion eye conditions contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

6. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

**N/A**

7. Please record the corrected visual acuity.

	Right eye	Left eye
Corrected Visual Acuity	6/6.	6/5.

Doctor's signature

DR JOHN ANTOON

1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date

18/06/08.

4. Has he undergone phlebotomy for Anaemia, Unspecified in the last 12 months?  
☒ No ☐ Yes U (record the time in weeks between each phlebotomy session)

5. Are the described symptoms due solely to Anaemia, Unspecified?  
☒ Yes ☐ No U (please describe the proportion Anaemia, Unspecified contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

6. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

DR JOHN ANTOON  
1A TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Doctor's signature

Doctor's name

Date

18/06/12

6. Has a restricted or exclusion diet been prescribed for Diverticular Disease Of The Colon?

☐ No ☒ Yes U

(please provide details)

Healthy diet

7. Have any procedures been undertaken or proposed?

☐ No ☒ Yes U

(list all procedures undertaken or proposed. For stomas, state if temporary or permanent)

colonoscopy, new report

8. Are the described symptoms due solely to Diverticular Disease Of The Colon?

☐ No ☒ Yes U


(please describe the proportion Diverticular Disease Of The Colon contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

(no symptoms)

9. If you answered NO to the preceeding question, please list all other conditions that contribute to the symptoms.

n/a

Doctor's signature



DR JOHN ANTOON

Doc 15 TURNER ROAD

BEROWRA HEIGHTS NSW 2082

Ph: 9456 2800

Date

18/01/20

8. Does he use any treatment for Lumbar Spondylosis?

☐ No ☒ Yes U

(provide details including any surgery and comment on effectiveness of each modality)

pen killers

9. Are the described symptoms due solely to Lumbar Spondylosis?

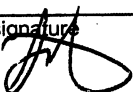
☒ Yes ☐ No U

(please describe the proportion Lumbar Spondylosis contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

10. If you answered NO to the preceding question, please list all other conditions that contribute to the symptoms.

Mr

Doctor's signature



DR JOHN ANTOON

Doctor's name

12 MILLER ROAD

BEROWDA HEIGHTS NSW 2082

Ph: 9456 2600

Date

6/2/17

6. Are there any persistent side-effects of treatment?

☒ No

☐ Yes **U**

*(describe the side-effects and state whether of a temporary or permanent nature)*

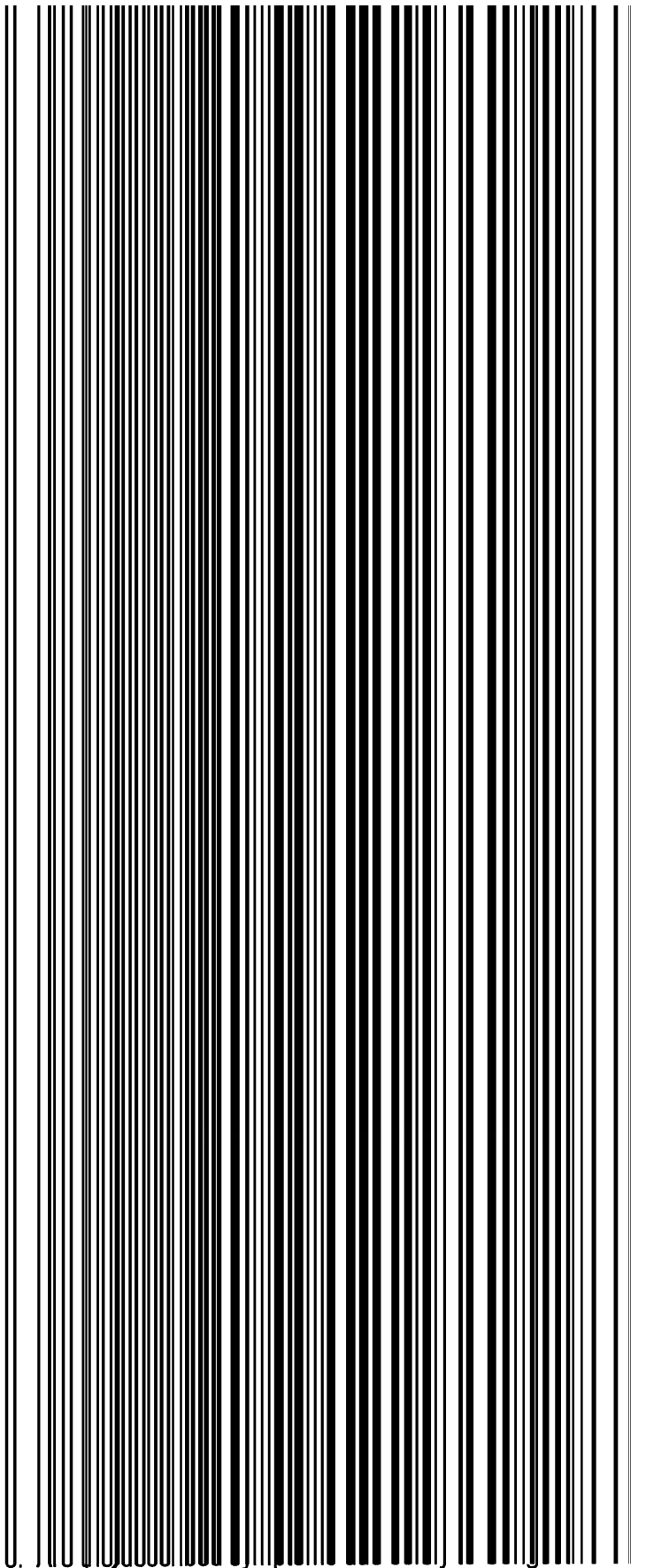
Doctor's signature

DR JOHN ANTOON  
1A TURNER ROAD

BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date

18/1/12



☒ Yes ☐ No ☐

(please describe the proportion Congestive Cardiac Failure contributes : completely, about three quarters, about two thirds, about half, about one third, about one quarter, not at all)

4. If you answered **NO** to the preceeding question, please list all other conditions that contribute to the symptoms.

N/A

Doctor's signature

DR JOHN ANTOON

1 ADDISON ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date

18/1/17

Doctor's signature

CPDISFIG 04/99

DR JOHN ANTOON  
1/4 TURNER ROAD  
BEROWRA HEIGHTS NSW 2082  
Ph: 9456 2600

Date  
18/11























